March 2015

Montana Central Tumor Registry Newsletter

Montana Cancer Control Programs
Chronic Disease Prevention & Health Promotion Bureau

Coding Primary Payer at Diagnosis

Source: NAACCR Central Registry Webinar, March 5, 2015
Speaker: Recinda Sherman, MCH, PhD, CTR, Program Manager, Data Use & Research, NAACCR

Primary Payer identifies the patient's primary payer or insurance carrier at the time of initial diagnosis. This code can become complicated because a patient may seek initial medical care without insurance and subsequently be diagnosed with cancer. Often, the patient may obtain Medicaid or a state-funded insurance after the initial visit and cancer diagnosis and this is what the registry may code in the Primary Payer field. This is not correct.

This item is used as an indicator for patient outcome so coding the payer at diagnosis is vital. It's a snapshot of their first visit. We need to think of this field as a "research" field and think about why we are collecting this data item. We don't want to know just who is paying for the patient's care, we want to know what was the patient's insurance status at their first visit at diagnosis. The patient's insurance status may have postponed medical care and could affect their stage, treatment, outcome, quality of life, and survival.

The rules say to record the payer at the time of diagnosis and not to change this if the patient's insurance carrier or payer changes. If your facility did not diagnose the patient and is only treating the patient, then code the insurance as reported on the patient's first visit to your facility. Again, it's a snapshot of their first visit at your facility with cancer.

Primary Payer Q and A

Q1. A patient was diagnosed with lung cancer at your facility on 1/5/15. At that time the patient did not have insurance. The patient came back two months later for adjuvant treatment. At that time he was insured through Medicaid. What Primary Payer code would be used?

A. 01 Not insured
B. 10 Insurance, NOS
C. 31 Medicaid
D. 99 Insurance Status Unknown

Q2. A patient was diagnosed with prostate cancer at your facility. At that time he was insured through Blue Cross Blue Shield with an 80/20 plan. What Primary Payer code would be used?

A. 01 Not insured
B. 10 Insurance, NOS
C. 20 Private Insurance: Managed care, HMO, or PPO
D. 21 Private Insurance: Fee-for-service

Continued on page 2

Cancer Surveillance & Epidemiology Program Staff

Laura Williamson, MPH
Program Manager
(406) 444-0064
lwilliamson@mt.gov

Debbi Lemons, RHIA, CTR
Coordinator, Montana Central Tumor Registry
(406) 444-6786
dlemons@mt.gov

Diane Dean, MS, CTR
Data Control Specialist
(406) 444-6710
ddean@mt.gov

Paige Johnson, BS, CTR
Data Control Specialist
(406) 444-6709
paigejohnson@mt.gov

Valerie Weedman
Logistics Coordinator
(406) 444-5442
vweedman@mt.gov

FAX: (406) 444-6557

MONTANA DPHHS
Healthy People. Healthy Communities.
Department of Public Health & Human Services

Meet the Registrar

D'Ann Silva, CTR, Cancer Registrar
St. Peter's Hospital, Helena, MT

I grew up in the rural country town of Lockeford, CA with a population of 750. Lockeford is known as the "Gateway of the Motherlode" and began as a gold mining town in the 1840s. Lockeford and the surrounding communities are also known for agriculture with vineyards, orchards, and livestock, living up to the description as the "Heart of the Valley."

I attended school in the area and completed my college education at California State University, Stanislaus.

We had a family business involving thoroughbred horses, so I have a keen interest in equestrian sports, such as racing and polo. My other hobbies and interests include the sport of fencing, classical ballet, cooking, hunting, and fishing.

The highlights of moving to Montana have been the friendly people and the amazingly diverse landscape.

Primary Payer at Dx Continued

Q3. A patient presents to your clinic on 01/16/15 with cough and cold symptoms. He refuses chest x-ray offered due to having no insurance. He returns on 01/21/15 with progressive symptoms and with balance problems. He agrees to a chest x-ray which is diagnostic for lung cancer. On 02/05/15 he contacts the local Veterans Affairs (VA) hospital and they accept him, with VA coverage retroactive to 1/15/15. What is *Primary Payer at Diagnosis?*

A. 01 Not Insured or 02 Not insured, self-pay
B. 20 Private Insurance NOS
C. 31 Medicaid
D. 67 Veterans Affairs

Q1. A
Q2. B
Q3. A

Q4. For the question above, how come it's not veteran affairs instead of not insured? His coverage was retroactive back to 1/15/15 a day before his visit.

A: Although his coverage is retroactive, ensuring his treatment is paid for, he had no insurance at time of diagnosis. And due to having no insurance he postponed medical care (he refused chest x-ray). Although he did receive chest x-ray a few days later, the decision to postpone was not based on medical best practices but on a financial decision. In many cases, patients will prolong seeking medical care for months or even years, leading to poorer health outcomes.

Consider this as a research question: Are there access issues in the VA system that lead to patients being more likely to be diagnosed at a late-stage? In order to answer this question, we need to correctly define VA patients. If we lump in patients covered by VA only after a cancer diagnosis, we could erroneously come to the conclusion that VA has barriers in access to care that lead to more patients getting diagnosed at late-stage. When, in fact, the barrier to timely treatment wasn't the VA but the lack of insurance.

Continued on page 4

Save the Date

Montana Cancer Registrars Association
Annual Spring Meeting

May 7-8, 2015

Red Lion Colonial Hotel, Helena
Room block is set up for the 6th, 7th, and 8th
Single $99/day, Double $109/day, King $109/day
Contact D'Ann Silva,dsilva@stpetes.org for more information
Speaker: Kendra Hayes, RHIA, CTR

Topics:
Revamping Cancer Conference
Using CP3R data
Survivorship plans
Stage Data: Using AJCC Manual 7th Ed. and Summary Stage 2000 (webinar)
Cancer Registry Studies
Genetics
Multiple Myeloma
Many more...

Certificate of Excellence Recipients

The following facilities received a certificate for the 2014 Fourth Quarter, acknowledging their timeliness in reporting. Ninety percent of their cases were reported within 12 months.

Facility	City
Physicians:	
Yellowstone Dermatology	Billings
Advanced Dermatology of Butte	Butte
Dermatology Assoc of Great Falls	Great Falls
Helena Dermatology	Helena
Associated Dermatology	Helena
CPG Dermatology	Missoula
Hospitals:	
Billings Clinic	Billings
St. Vincent Healthcare	Billings
Teton Medical Center	Choteau
Rosebud Health Center	Forsyth
Kalispell Regional Medical Center	Kalispell
Phillips County Hospital	Malta
St. Patrick Hospital	Missoula
St. Joseph Medical Center	Polson
Ruby Valley Hospital	Sheridan
Broadwater Health Center	Townsend
Pathology:	
Yellowstone Path Institute	Billings

What's new for 2015 reporting?

Although there are no new data items in 2015, there are several changes in instructions and code options. Updates to the MCTR 2015 Reporting Manual will be complete early summer. Updates and changes will be highlighted in yellow.

- Carcinoid tumors of appendix are now coded 8240/3 (formerly 8240/1). Make note of this in your ICD-O-3 book.
- Enteroglucagonoma, NOS and Enteroglucagonoma, malignant are now coded 8152/1 and 8152/3, respectively (formerly 8157/1 and 8157/3). Again, note this in your ICD-O-3 book.
- Country Codes are updated for Yugoslavia (YUG) and Czechoslovakia (CSK) (formerly XCZ and XYG).
- Grade Path Value and Grade Path System are no longer required (only required 2010-2013).
- Six drugs were reclassified from chemotherapy to BRM/Immunotherapy as of 2013 (Alemtuzumab/ Campath, Bevacizumab/Avastin, Ritiximab, Trastuzumab,Herceptin, Pertuzumab/Perjeta, and Cetuxumab/Erbitux).
- Sex codes have been updated: code 4 = Transsexual, NOS; code 5 = Transsexual, natal male; code 6 = Transsexual, natal female.
- Directly coded SEER Summary Stage, Clinical AJCC TNM Staging, and Pathologic AJCC TNM staging are required in addition to Collaborative Staging.
- Coding biopsies followed by surgery is clarified: if a needle biopsy preceded an excisional biopsy or more extensive surgery, even if no tumor remained at the time of surgery, both the needle biopsy and the surgical procedure of the primary site are to be reported.
- Reporting dose for photon treatment has been clarified: for photon treatment, dosage is reported in cGe units (Cobalt Gray Equivalent) rather than cGy. Record 100x cGe for Regional Dose: cGy (note that it is necessary to multiply cGe by 100 to code this).
- Various other corrections, clarifications, typographical errors have been added or fixed and will be highlighted in the upcoming MCTR 2015 Reporting Manual.

Primary Payer at Dx continued

Q5. Why would you not code "10 insurance, NOS" if the state is paying for the treatment?

A: Remember, the variable is Primary Payer at DX. There is discussion regarding adding Primary Payer at Treatment. If the patient is on some other state insurance prior to diagnosis, then use 10-insurance, nos. If they are already on Medicaid, then use 31-Medicaid. If the state is paying for treatment via Medicaid and the patient was not enrolled by the hospital at the time of diagnosis, then code 01, Not insured. If the state is paying for treatment through programs like the Breast and Cervical Cancer Program (BCCP), by definition the patient did not have insurance at time of diagnosis. The patient is only eligible for treatment to be paid for by the BCCP if the patient meets specific eligibility criteria including no other insurance and a cancer diagnosis. BCCP, other site-specific funding like through Lymphoma and Leukemia Foundation, and patients who are enrolled in Medicaid after a cancer diagnosis are coded as **01, Not Insured**.

Q6. If insurance is pending, do we code it to code 99?

A: If "insurance is pending" means the patient has enrolled in a Medicaid or other insurance and the paperwork is processing, then code **01, Not insured**. Again, the variable collects Primary Payer at DX not necessarily at treatment. Only use 99 if there is no way to determine if the patient has or does not have insurance. This situation should be rare. In most cases, the patient is either uninsured or can be classed into Insurance, NOS.